In March the department had the opportunity to put on a porcine cardiac dissection for our residents, faculty and fellows. We were fortunate to have Drs. Stan Shernan and Doug Shook from the Brigham and Women’s Hospital as our instructors. Stan is my closest friend and Doug is Jake’s, so it was great to have them in town.

As I participated in the event with Jake, I could not help but see the similarities between Stan and Doug and Jake and I. Stan and I have been actively mentoring Doug and Jake respectively to take our places eventually within the Society of Cardiovascular Anesthesiologists (SCA). As we prepare to pass the baton to the next generation, it has been amazing that with some support, both men have developed completely new areas of growth within the SCA. Both have led efforts to develop a fellowship track within the annual meeting, and Jake is actively developing expertise within the patient safety arena through his involvement with FOCUS.

Webster’s dictionary defines mentoring as “to serve as a trusted counselor or guide.” It is my desire that our department, through the wise counseling of Fred Guidry, Jerry Reves, Frank McGowan, John Schaefer and others, will become known as a department that develops and mentors its junior faculty to become the next generation of educational, research and clinical leaders within our specialty.
CARDIAC WET LAB DISSECTION
BY: SCOTT T. REEVES, MD, MBA, CHAIRMAN

The department was fortunate to have Drs. Stan Sherman and Doug Shook from Brigham and Women’s Hospital present on March 12 to lead a porcine cardiac dissection. The title of their presentation was “Dissection of Porcine Heart with Echocardiographic Correlation.” The residents, faculty and CT anesthesiology and pediatric cardiology fellows participated. It was an excellent opportunity to learn cardiac structure anatomy and its relationship to Echocardiographic principals.

This opportunity would not have been possible without the assistance of our CRNAs who volunteered to cover that evening in order to relieve the residents. We want to especially thank Tina for her scheduling expertise and our chief CRNAs Wendy, Jodi and Nancy. Tony and Angie volunteered to stay and open the CHP classroom for us and run the AV equipment, they deserve our thanks. Finally, thank you to Leslie who coordinated the arrival of all the supplies, the hearts and the clean up.

Anesthesia Residents:
Ebony Hilton, MD and Monica Williams, MD

Anesthesia Residents:
Ryan Nobles, MD and Heather Scott, MD

Pediatric Fellows from left to right:
Jeff Harris, MD, Suma Potiny, MD, Kim McHugh, MD, &
Kimberly Jackson, MD
Jake Abernathy and Scott Reeves participated in this multidiscipline course with adult and pediatric cardiologists, surgeons and anesthesiologists. The course was directed by Dr. Girish Shirali who is the chair of the MUSC’s Children’s Heart Program and Chair of Pediatric Cardiac Imaging. Jake and Scott participated on Sunday, March 13 in the session entitled, “Normal Heart Dissection, 2DE and 3DE Correlations (TTE and TEE).”
The first regional anesthesia afternoon workshop was held last month on Thursday, February 17th. Pertinent anatomy and ultrasound imaging of the brachial plexus was reviewed with a lecture and then participants were given the opportunity to practice their ultrasound skills on two standardized patients. The workshop was a great success with faculty, medical students and residents participating. Many thanks to Drs. Mike Hay and Ryan Gunselman who assisted with ultrasound imaging.

This initial workshop is one of five that are planned for the spring. The intention of the sessions is to review the anatomy and anatomic landmarks pertinent to a nerve block or group of blocks, show how ultrasound may be utilized, and provide practice with ultrasound imaging of the discussed material. Sessions are Thursday afternoons from 3-5pm in SEI Conference Room 314 and do not interfere with other resident curriculum activities.

The workshops are designed to have everyone stop by for 15-20 minutes as they are leaving work (longer if they like) and gain both knowledge about regional anesthesia and experience with the ultrasound. Two faculty members work with participants to ultrasound standardized patients and a short lecture runs repeatedly (presented by a third faculty member if available). Therefore, participants can join and leave the workshop at any time.

Everyone gave wonderful feedback from the initial workshop. The primary comment was a request for more room and we are looking into this in the future. Another comment was to have less material per session as some people were overwhelmed with four different peripheral nerve blocks last month. Consequently, two were covered in March: transversus abdominal plane blocks (TAPS) and rectus sheath blocks.

We encourage everyone to participate and welcome any feedback.

Dates for workshops are as follows:

**April:** Thurs, 4/7; Lower Extremity Peripheral Nerve Blocks
**May:** To be determined
**June:** To be determined
It's that time of year again! We are proud to announce our team of medical students who will be doing research in our department this summer. Karina Geronilla and Luke Dong were awarded the Foundation for Anesthesia Education and Research (FAER) Medical Student Anesthesia Research Fellowship (MSARF). Julius Hamilton was awarded the Dr. J.G. Reves Research Fellowship and Korey Rentz was awarded the Dr. Laurie Brown Research Fellowship. Karina, currently a first year medical student at the West Virginia University, will be working on research concerning intraoperative point of care testing for coagulation disorders with Dr. Finley. Luke, currently a first year student at MUSC, will continue his previous work on Transcranial Magnetic Stimulation with Dr. Reeves. Julius, currently a third year student at MUSC, will be working with Drs. McEvoy, Field, Clark, Furse, and Rieke on simulation education research. Korey, currently a first year student at MUSC, will be working with Dr. McGowan on projects concerning coagulation in pediatric cardiac anesthesia. All of these students are rising stars! Please give them a warm welcome when you see them around the department this summer.
We would like to recognize Dr. Ilka Theruvath for demonstrating extraordinary work ethic. Dr. Theruvath was nominated to receive the prestigious “Applause” certificate given by MUSC for going beyond the call of duty. Dr. Theruvath was nominated by the nursing staff in the PACU for her “extreme diligence and care for a patient.” The Department of Anesthesia would like to recognize her for being an outstanding team player!

The MUHA Health Information Services Department is the overseer of all health information. All requests for copies of health information must come to the HIS department for processing (except Carolina Family Care). All requests received from any legal entity should go to the HIS department for disclosure. If you send information to an attorney, then if required, you will have to attest to the authenticity of the record which will leave you accountable.

The UMA Compliance Department will continue to monitor the requirements regarding the HITECH Act. We are currently working with the MUHA Health Information Management Department on several projects including the HIPAA/HITECH/Release of Information training classes for staff on the front line.

For more information, please contact Suzanne Collins, RHIA, CPC, CEMC in the UMA Compliance Department, collinsu@musc.edu, 876-1323

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**BIRTH ANNOUNCEMENT!!**

Congratulations to Joe Whiteley, MD and his family on the new addition to their family!

**Ryan Jonathan Whiteley**
7 lbs 11 oz, 20 inches
Born March 9, 2011
SimonTunes, an MUSC spin-off company, announced it will offer patient simulation educational material developed at MUSC’s Health Care Simulation of South Carolina (HCSSC) beginning this April through SimStore on the Internet.

The development marks the advance of better, standardized simulation technology training offered worldwide that will result in a better-trained health care workforce. Training through patient simulation is thought to reduce medical errors and improve patient safety overall, similar to the effects of its use in other industries, such as commercial aviation.

John J. Schaefer III, M.D., holder of the Lewis Blackman Endowed Chair at Health Sciences South Carolina and MUSC Simulation Center director, said what he really likes about the project is that licensing simulation learning systems serves the main missions of improving patient safety and the education of health care students, all while generating resources and jobs in South Carolina.

Charleston mayor Joseph P. Riley, Jr also supported the development.

“I am thankful for the vision and support of the leadership in the Health Sciences South Carolina and S.C. Legislature in supporting the endowed chairs program,” he said. “Today’s announcement is a most extraordinary example of MUSC’s research activity creating a health sciences company that will deliver groundbreaking, life-enhancing services to the world.”

SimStore (http://simstore.com/) will sell a wide range of medical simulation educational material. It was established by SimVentures, a joint venture between HealthStream Inc., a leading provider of learning and research solutions for the health care industry, and Laerdal medical, the world’s leading provider of resuscitation education products and patient simulators.

With scenarios and other content already created by HCSSC and other leading educators from around the world, SimStore will serve as a hub of educational content for multiple health care disciplines. SimStore will offer for purchase more than 1,000 scenarios—with thousands more to follow—from some of the world’s leading health care organizations and associations that together form a leading developer network. Academic medical institutions that use simulation education will benefit from access to scenarios that are standardized to equalize training, instruction material needed for the simulation teacher, and extensive debriefing sections that enable researchers to study simulation training effectiveness, and eliminate the need for a full-time simulation specialist because individual educators can master the content to pass onto students. By April 1, SimTunes expects to have more than 300 simulation scenarios available through SimStore.

Heyward Coleman, president of SimTunes, said SimStore is going to be very effective in distributing educational material developed at HCSC to centers that employ patient simulators around the world. “HealthStream, the leader of online education to hospitals in the United States, and Laerdal, the largest producer of patient simulators worldwide, are the ideal partners to make SimStore a dominant factor in the field of educational material for the simulation industry,” he said.
LUNG TRANSPLANT PROGRAM IS REINSTATED!
BY: ERIC NELSON, DO

MUSC revived its lung transplant program with its first case recently, a double lung transplant that took place at Ashley River Tower (ART). The anesthesia team consisted of Drs. Eric Nelson, Scott Stewart, and Becky Payne. The surgeons were Drs. Will Yarbrough, John Ikonomidis, and Chad Denlinger. The surgery couldn’t have gone better. The transplant was performed on bypass with the heart beating. Separation from bypass was uneventful and we were able to ventilate the patient with an FiO2 of 40% and did not require nitric oxide, pulmonary vasodilators, or inotropes. The patient was extubated on postop day 1 and has been doing well since the surgery.

The surgery and anesthetic care demonstrated great communication and collaboration between anesthesiologists, surgeons, and pulmonologists throughout the entire case. This was especially important as a heart transplant had to be coordinated to go at the same time (this was done by Dr. Alan Finley, and Marianne Fiutem, CRNA).

THE MIRACLE OF A DOUBLE LUNG TRANSPLANT
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Donor lungs become available and candidates at the top of the waiting list are considered for transplantation. The appropriate recipient is called to come to MUSC and is prepared for surgery. Simultaneously, a lung-recovery surgical team is dispatched to the donor hospital where the donor lungs are assessed and inspected. If the lungs look good, then the transplant surgeon and anesthesiology staff at MUSC are notified so that final preparations can be made.

The recipient is placed under general anesthesia and monitoring lines are carefully inserted. An incision is made down the middle of the chest so that the breastbone can be divided (i.e. sternotomy). This incision is the same incision that is used for “open-heart surgery” and is the preference of the MUSC lung transplant team. The incision down the front of the chest (“open-heart incision”) requires the recipient to be placed on the heart-lung machine for cardiopulmonary bypass during the transplant.

At MUSC, the heart-lung machine is used for carrying out double lung transplants and this allows both diseased lungs to be removed from the chest cavity of the recipient in a stable fashion. Removal of the diseased lungs includes division of the airways as well as the arteries and veins carrying blood towards and away from the heart, respectively. Upon arrival to MUSC, the new lungs are quickly, and safely, sewn into the chest of the recipients. The airway of one lung is connected first. Then the veins carrying oxygenated blood away from the lung are sewn to the left atrium of the heart. Finally, the pulmonary arteries carrying deoxygenated blood towards the lung are connected.

The same process is repeated on the other side with the goal being to have both lungs sewn into place in less than six hours from the time of their procurement at the donor hospital. The new lungs are gently ventilated and the recipient is separated from the heart lung machine. Drainage tubes are inserted around the lungs to evacuated fluid and the chest is closed. Patients are transported to the intensive care unit where they are closely monitored and are taken off the ventilator as quickly as possible. Medications are administered that suppress the recipients immune system so that they do not reject the lungs. These medications are continued indefinitely. After spending a couple days in the intensive care unit, patients are promoted to the step-down unit where aggressive rehabilitation begins. Patients typically remain hospitalized anywhere from 10-20 days.
The first thing Evin Evans wants to do when she gets out of the hospital and home to her farm is to take off her shoes, bury her bare feet into the earth and breathe.

Breathe without it feeling like she’s sucking air through a piece of lava.

Breathe without the burden of oxygen tanks weighing her down.

“I want to reconnect to the land,” she said in her hospital room as she began the tough road of recovery from her March 9 double-lung transplant. “I’m not ever going to take it for granted. Taking a breath is phenomenal. This is a big deal. It’s a big deal for me. It’s a big deal for MUSC.”

Kim Phillips, RN, and transplant service line administrator, said this completes the one missing piece of a well-established, multi-organ transplant center. It also means that organs can remain in state as was the case for the last transplant where the three viable organs remained in the state and went to patients at MUSC.

Evin, who learned that two other patients also were recovering at MUSC having received organs from the same donor, got teary as a friend told her it was like she had cousins now.

She took in the news, nodding. “It’s like we’re family,” Evans said of the gift. An organ donor herself, Evans said no one knows until their life depends on getting an organ and what it feels like. “On one level, I underestimated how grateful I would feel. It’s a gift beyond what you can imagine.”

MUSC had a lung transplant program from 1994 to 1997, but it was discontinued after the chief surgeon left. With the completion of Ashley River Tower and the key recruitment of Timothy P.M Whelan, MD, of the University of Minnesota to be the lung transplantation medical director and William Yarbrough, MD, of Stanford University as surgical director for the lung transplant program, MUSC was able to offer the program again.

Whelan said MUSC is better prepared now as there is a core group of surgeons involved and the project is supported on all levels by the hospital, including the departments of surgery and medicine.
Continued...

Whelan and Yarbrough were pleased by Evans’ progress. She was breathing on her own without oxygen 24 hours after coming out of the operating room, and discharged after nine days. The average length of stay nationally for a lung transplant is 22 days.

Evans needed lung transplantation because she had end-stage lung disease as a result of lung fibrosis. She was impaired to a large degree with respect to performing basic activities and was dependent on supplemental oxygen, said Yarbrough.

“Quite frankly, she remained short of breath most of the time and was miserable as a result. Without lung transplantation she would not likely have survived more than another year or so. She really didn’t have any other options, and it was fortunate that she was otherwise in good condition so that she could become a transplant candidate,” he said. “Her success is a testament to her fortitude as well as to the excellent care she has received from numerous individuals at MUSC.”

Both doctors are glad that patients now can receive care closer to home and face shorter wait times related to allocation of organs for transplant. Phillips said the program has benefitted from the hard work of a great team with amazing leadership. “We never have to send lungs away. Local lungs can stay locally. I’m so excited. This is a great resource to have.”

Evans, 60, was dual listed for her transplant at MUSC and Emory University of Medicine, but said she was glad to end up in state. “I felt I would gain a lot of personal attention and I have,” she said, adding that she had done her research on her team and felt she was in safe hands. “I had been embraced by the medical community in a way I haven’t before in other places I’ve been.”

Owner of Split Creek Farm that is known for its award-winning goat cheeses, Evans knows all her 350 goats by name. She’s eager to return home when she finishes her pulmonary rehabilitation. She said she knows her life will be more constrained, but it won’t be like it was. Before she couldn’t even fly to the international competitions she was asked to judge because of all the oxygen equipment she was required to keep with her. Even walking across a room tired her, and she had to take her oxygen with her to shower.

Evans said she has spent one-third of her life in denial about her illness, one-third crying and one-third angry and depressed. Now that she has a second chance, she smiles.

The next portion she wants to spend in gratitude.
“THE BEST MONTH OF MY RESIDENCY”
BY: WILL HAND, MD, CHIEF RESIDENT

The title of this piece is the only way I could encapsulate the month spent in Tanzania through the Madaktari program (http://www.madaktari.org/) in one sentence (as I had been asked to do). If you’ve talked to me in person about it I hope my enthusiasm was obvious, but if not please read on and perhaps I can encourage more people to take a chance, fly to Africa for a month, and come back changed!

I was positioned at Weill-Bugando Regional Medical Center (http://www.bugandomedicalcentre.go.tz/) in Mwanza, Tanzania. This 800 bed hospital has been selected as a site for the advancement of medical education by several international organizations, Madaktari being the newest. I was there for approximately one month and came with unknown expectations. I left with unexpectedly profound insight into life, medicine, and distributional ethics.

My most specific objective was to provide clinical medical expertise (OR teaching) and basic science didactics. I fulfilled these to the best of my ability interacting with the class of 14 anesthetist students daily and delivering 17 lectures on topics from basic pharmacology to ultrasound guided regional blocks (not currently available). This, however, proved to be just the beginning of what a US-trained anesthesiologist can offer at “Bugando.” After meeting clinicians in the ICU, NICU, Ortho ward, and surgeons, I ended up consulting on management throughout the hospital. Unlike the American system of medical sub specialization, I followed patients throughout the hospital with varying perioperative pathologies.

Perioperative morbidity and mortality statistics for “all-comers” in sub-Saharan Africa vary widely in reports and seem difficult to validate, but the hospitals in Tanzania are viewed as places sick people go and often don’t return. Evidence of this is the series of casket vendors that line the street leading to the hospital compound. A few of the patients I took care of died during my month in Mwanza, and most of the deaths I was aware of occurred for reasons that appear “preventable.” With simple (but continuous and thorough) education, the delivery of high quality perioperative care is within reach!

Outside the hospital, real life came back into focus for me. Gone was the ever-present blinking LED on my blackberry (indicating new messages). Several days there we had no electricity, but it proved less relevant than it might here since we never had TV, internet, computers, or air conditioning. In exchange for losing all the “stuff” that occupy our lives, I found that face-to-face communication with one’s very own mouth and ears is even more effective than a finely worded “reply all”… Without the distractions that I fill my life with here in the US, we spent our evenings exchanging stories over 2-hour dinners (a lot of Indian food, rice, beans, and mystery meat!!!) and exploring the city. I lived with 4 residents/fellows from Cornell who all came with different expectations and experiences. The rotation of new visitors gave each of us a turn being the shell-shocked new person and also the well-vested “local” who can show the next person the ropes. I trust some of my roommates will be friends for life.

In addition to the extensive clinical exposure the rotation provided, my time in Tanzania also afforded me the time to experience the unparalleled beauty that they take for granted every day. The first weekend we visited Mt Kilimanjaro (the tallest Mt in Africa). Later, I took a two day safari into the Serengeti with one of my roommates where we saw thousands of animals in their natural environment (wildebeest, giraffe, elephants, lions, zebra and leopard). My last weekend was spent on the azure beaches of Zanzibar in the Indian Ocean. I wanted to throw these stories in just to seal the deal that more of us will go!!

I left Tanzania with mixed emotions. No one is scheduled to return until September, and I fear that education will cease in our absence. I fear for the complicated patients who may die with lack of access to the quality of care we consider “standard.” I fear that hundreds of people will suffer and I will be here placing my 300th labor epidural and studying minutiae for written boards… however, I also know that the students must have learned something and will provide modestly improved care because of the MUSC-Madaktari efforts. I have been in communication with the students since my return; clinical consults and social communication provide a way for me to continue to extend myself to them. I look forward to continued participation and achieving the long-term goal of a sustainable education model that will help equip Tanzania with qualified medical personnel to care for their population.
Globalization Efforts: Communications from Tanzania
By: Drs. Buddy Inabinet & Will Hand

Tanzania Emails: One of the best ways for the department to understand the impact we are having on the Tanzania medical personnel is by reviewing the emails sent from our department members. Below is the collection from Will Hand and Buddy Inabinet during their time in Mwanza from February-March 2011.

From: Hand, William
Sent: Monday, February 07, 2011 9:35 AM
Subject: First day at Bugando

Dr. Reeves,

Dr. Inabinet and I finally made it to Mwanza. I checked in at the Serengeti house and met a few other residents who have been here for approximately two weeks. We chatted about life and medicine, here and at home until well after midnight. They were trying to prepare me, I think, for what I would see today.

We met before morning report and were introduced to the anesthesia students. Dr. Matasha arrived and the students presented, orally, the 30 or so patients posted for surgery today. Since it was the first day, we didn't make any commentary, but privately discussed cases with the teams as they were being performed.

Day one presented me with new challenges as some picture I have taken will depict-- I'll send you them once I can upload them. We had a 68 y/o woman with a tumor on the anterolateral aspect of her neck (pictured below) that was approximately 75% the size of her head (weighed 17lbs once excised). She had bilateral clubbed feet-- so perhaps multiple other abnormalities... not looked into. The anesthesia plan for this incredible mass-- IV induction with Sux... laryngoscopy and expectant intubation. Dr. Inabinet and I held our breath as they forged ahead-- the first attempt failed... difficult mask ventilation... they called for the bougie (from another room), and fortunately were able to intubate the patient. One hour (yes one hour!!!!) later, the tumor was removed and the patient is expected to recover well.

Two children had orthopedic surgery-- one with an osteosarcoma (reportedly) which has externalized to form a tumor with a diameter five times that of the host tibia. He had an amputation (his disarticulation)-- I fear for his future with such a handicap. The second boy, 8yo I saw limping (hopping, rather, with the occasional step on his right leg) to OR 4. Once he was on the table and had a spinal in they took down his leg dressing which revealed a totally-displaced compound tib-fib fracture with 3 inches of bone missing. This boy hadn't shed a tear or grimace.

One day down and I have been challenged clinically, ethically, and emotionally. We start lecturing tomorrow and will attempt to work our way into the OR-teaching as we gain their trust. The potential for our impact is tremendous; the practitioners are capable and eager to learn-- the patients desperate. We have already met several other Americans here from other hospitals and organizations; we are not alone in this!

Thank you for your prayers, please continue to pray for the people of Mwanza too as we meet them one at a time in impressive circumstances,

William R. Hand, MD
Globalization Efforts: Communications from Tanzania
By: Drs. Buddy Inabinet & Will Hand

On Feb 9, 2011, at 8:37 AM, Hand, William wrote:

Dr. Reeves and McEvoy,

Bugando says hello-- I have big shoes to fill over here between you, Carlee, and Rob! I'm working my way into teaching a lot in the OR and have given a few lectures. I'm sure many people have covered the pharmacology before me, but they asked for it and clearly needed another refresher. etCO2 keeps coming up in my teaching and they have no idea what it is-- they seem to think we're blowing it IN, like Halothane... my goal is for them to understand that it comes from the patient before I leave.

We had a very salient teaching point this AM at morning report... apparently they aren't in the practice of preoxygenating the RSIs... we talked about the benefit of that. We've done 2 LMA cases and I did 2 ortho cases with regional in the hallway! Half of the cases were cancelled today because they ran out of sterile linens; this is apparently becoming more and more common.

I rounded in the ICU today and think we're going to have a case like your kiddo with tamponade coming down. He has anterior mediastinal mass, bilateral pleural effusions, and pericardial effusion (new). Abdominal distension. We're guessing lymphoma and they started giving decadron today. I don't think the outcome will be good, but we are apparently going to do a biopsy vs. resection if possible in the next few OR days. The ICU is down to one ventilator, so all cardiac cases are on hold (as are intubated unit patients, I guess).

Tanzania is more beautiful than I had imagined... the city grows around Lake Victoria like Monaco does the ocean -- we hiked Dancing Rock last night for sunset!

Dr. Inabinet and I went to the campus church this AM (English on Wednesday). Fr. Highlife went to seminary in Chicago... small world. The faith of the people here is inspiring. I plan to visit the churches of some of the anesthesiologists and students-- they have already asked me to come with them. It is an honor.

All my best to you and your families,

William R. Hand, MD

From: Hand, William
Sent: Friday, February 11, 2011 3:19 PM
Subject: Week 1

Dr. Reeves,

Today we assisted in performing the first mobile endoscopy at Bugando Medical Center. There was a patient admitted Tuesday with hypotension, nausea, and melena. One of my roommates is a graduating GI fellow from Cornell and he tried to scope the patient in the GI suite. Upon insertion of the scope the patient wretched and vomited 4-5L of bilious bloody fluid. They aborted the procedure and were unsure about aspiration. Tuesday his Hemoglobin was 3.5... they transfused him 10U PRBC (and never rechecked H/H!!!!!) in the ICU but they had no way to do endoscopy/banding. My roommate and I approached the department heads of anesthesia (Matasha), GI, and the ICU (Peck) to ask if we could bring endoscopy to the ICU (where there are monitors) and intubate the patient for the procedure (never done here). After they apparently discussed it Thursday, we had to go-ahead for today's procedure.

I picked a few anesthesia students and we discussed everything we needed (drugs, suction, ambu, ETT etc...) and my roommate took the bolts out of the wall holding the endoscope monitor up and attached it to the cart. With an audience of about 20 people we intubated the patient (ketamine, thiopental, sux), performed endoscopy, banded 4 variceal bleeds, and extubated him 12-15 minutes later. He did great and they are planning to transfer him to the floor tomorrow.

Continued...
Globalization Efforts: Communications from Tanzania
By: Drs. Buddy Inabinet & Will Hand

From previous page...

We have several pictures, and the GI and ICU teams want them disseminated to Cornell and MCV to keep the momentum going. We gave a recap lecture to everyone who couldn't attend. I know in the USA this isn't a big deal, but this man would have died without treatment--a treatment that can continue to be provided as long as we can demonstrate its safety.

One week... felt like a month--in a great way!

William R. Hand, MD

2/14/2011

Scott,

The first week has progressed slowly “pole pole.”, although everything has gone well.

Will has given seven lectures and I have given one to the anesthesia students. The student’s level of anesthesia knowledge remains unknown. They seem to be hearing a lot of the information for the first time. The students have a curriculum, though I am not sure how closely it has been followed. We plan to lecture six times in the coming week. However Tuesday is a Muslim holiday and the operating room may be closed.

I lectured the students on the Mind Body Spirit model of patient care. We discussed the emotions of fear, sadness, pain, and loneliness that are so common in preoperative patients. I talked about how these feelings can greatly impact the perioperative stress response, thus resulting in an out flow of the ANS. I greatly emphasized the importance of listening to patients and addressing their concerns. Also, I presented my World View and how it relates to death and HOPE. Death is certainly very common at BMC….actually, when you think about it; it appears that we all will face it one day.

The anesthesia providers at Bugando hospital are able to stretch their resources and provide basic adequate anesthesia care. Frequently, I have been reminded how our health care system is burdened by excessive testing, prescribing, consulting, and surgery. That’s certainly the opposite here. They take basic drugs equipment and knowledge and do the best they can with these limited resources. They seem to have a reasonable amount of success in a majority of the cases. However, post-op care is questionable with an ICU with minimal equipment and only one functioning ventilator. Just last week they had a post-op spine surgical patient that died on the floor. Also, one of their post-op craniotomy patients that had a head injury died in ICU this past week. The concept of emergence from anesthesia and extubation needs to be carefully dealt with in the future.

In reference to the two candidates, Joel Karugaba and Damas Mkana, we plan to spend some time with them this week in the O.R. Joel’s background is EN 1999/RN 2009 anesthesia training 2001-2002 and BMC staff 2002 to present. I met him Friday and we briefly discussed the Madaktari program. He seemed to be very enthusiastic about it. Damas speaks slightly better English, but appears a little less enthusiastic.

Continued...
Globalization Efforts: Communications from Tanzania
By: Drs. Buddy Inabinet & Will Hand

Continued from previous page...

I had an interesting discussion with Dr. Matasha this week. Dr. Matasha started med school in 1972 in Germany, he was a medical officer in Tanzania in 1978, and he started anesthesia practice here in BMC in 1985. He states he has worked hard for very many years and is looking forward to retirement in two to three years. He does appear to be open and enthusiastic about help from MUSC. He states that the problem with anesthesiology in Tanzania is the very low pay and the inability to supplement income with an outside private practice. He feels anesthesiologists are not respected as much here as other areas of medicine. He would like to see a more continuous relationship with MUSC and others. He likes the idea of someone coming for an extended period of stay or at least every other month. He sees problems with someone coming every third month and staying for just a month. A good time for someone to come would be when the nurse training program starts (September). Dr. Matasha takes annual vacation from the middle of December to the middle of January. This could be an opportunity for us to work with him for one week and then run the operating room in his absence for several weeks. However, the Christmas factor may be a major issue for us. Also, I am not sure if they close some of the ORs. This would give us a chance to have more comprehensive pre-op discussions, and more direct involvement in anesthesia planning.

Continuing medical education is a definite problem for the anesthesia providers here. Dr. Matasha’s last CME meeting was 4 years ago in Germany. He has a ‘sincere’ interest in attending meetings, but is unable to do so because of inadequate financial support. ??

This also applies to most of the nurse anesthesia providers. 3 or 4 nurse anesthesia providers attended some type of conference last year in Nairobi. Another idea would be to send Dr. Matasha or a couple more of the experienced nurse providers to a local anesthesia meeting either in Kenya or Dar.

I will be in touch later.

Buddy Inabinet

Pictured Above:
Will Hand, MD, at the entrance to Bugando Medical Center

Pictured Below:
A leopard seen on Safari by Will Hand, MD
GLOBALIZATION EFFORTS: COMMUNICATIONS FROM TANZANIA
BY: DR. BUDDY INABINET & WILL HAND

Sunday, February 27, 2011 1:46 PM
Subject: Closing days in Tanzania

Dr. Reeves,

My month here is coming to a close, and I look forward to seeing my family, friends, and co-workers soon. That said, the work here is not done; and I am trying to help organize future efforts before I leave. I ended up giving 17 lectures covering basic pharm and phys, OB, Peds, Trauma, and a unique lecture covering schisto and malaria, just for their overall education. I gave two "tests" to evaluate learning and communicated with Dr. Matasha what areas need to be re-taught. By the end, every student is ahead of where they were one month ago, and I reiterate that their technical skills are quite good despite definite gaps in textbook knowledge.

Dr. Harvey would be proud-- I tried to convince the Operating Theater to start doing Time Outs. If I was in the room they would at least verify with the surgeon who the patient was and the procedure. At times they seemed frustrated, but my second last day may help it gain traction-- we were about to take a HUGE Wilms tumor out of a 3 y/o when we did the modified Time Out (I was going to do the case with students)... I asked the surgeon how much bleeding he expected... he said he had ordered 4 units of blood be available. This, apparently, was news to the anesthetists (responsible for this, perhaps?), so obviously we cancelled the case. Earlier in my stay there was NO communication between surgeon and anesthetists preoperatively. Notch one life up for the time out!

I think I emailed you about my day of pediatric thoracic cases-- I thought I'd update you to give perspective on the issues we'll face if we pursue a NSG program at Bugando. The 2 y/o sternotomy that we had to extubate post-op (the one ventilator was in use due to a code during surgery) did quite well. I worked with the (Cornell) ICU pediatrician to get the patient's pain under control before he was exhausted by her tachypnea. He stayed in the ICU for four more days and has since made it to the floor and continues to improve (awaiting pathology on the mass). The second child (9 y/o PDA ligation) did very well post-op on day 1. He didn't have any family visit, so I sort of adopted him. I'd stop and see him whenever possible and we hacked through communication since neither of us knew the other person's language. He'd smile when I came by after the OT (operating theater) slowed down or after my lecture. I was certainly feeling hopeful fulfilled by this interaction. Then, one morning, he wasn't there. I assumed he was transferred to the floor overnight for census reasons... but I was wrong. He had died during morning rounds. The team "thinks" he choked on food (REALLY!!!), but there was no autopsy and the (Cornell) resident said they were on the other side of the ICU when the nurse called them over to his bed. He was obviously cyanotic and before they could do much of anything he was beyond saving.

So, this, in combination with several similar stories, makes me wonder if BUGANDO is capable of providing care for NSG patients. I think the OT and anesthetists are close, but the postoperative care is way behind. Speaking with the Cornell team at length, they seem to indicate that monitors are relatively new and thus they don't "trust" (use?) them. Every single day I went through the ICU to find patients at beds with monitors... connected... but turned off. Obviously I'm not in the position to recommend changes, and the Cornell team is making progress gradually.

I look forward to discussing all that I've learned soon and hope to encourage the next team by the wonderful experience and tremendous opportunity that this trip provides.

Sincerely,

William R. Hand, MD
Message from the Chair

Frank W. Sellke
MD, FAHA

The Council on Cardiovascular Surgery and Anesthesia (CVSA) remains strong and committed to the goals of the American Heart Association. Thanks to the excellent work of Program Chairman Joseph Woo and other members of the Program Committee, the surgery and anesthesia specialties were especially well represented at this year’s Scientific Sessions in Chicago. A broad range of topics were presented covering nearly all aspects of cardiovascular surgery and anesthesia. Examples include percutaneous aortic and mitral valve therapy, aortic surgery, cell therapy, treatment of ischemic mitral regurgitation, surgery for heart failure, robotic and other novel methods for CABG, and the diagnosis, pathophysiology and management of heparin-induced thrombocytopenia.

This year, Dr. Jerry Reves presented the William W. L. Glenn Lecture, in which he discussed the development of cardiac anesthesia as a specialty parallel to the development of cardiac surgery. Dr. Reves just stepped down as Dean of the Medical University of South Carolina in Charleston. Previously he was chairman of the Department of Anesthesia at Duke University Medical Center. He is the first anesthesiologist to be named the William W. L. Glenn Lecturer. The Council’s Young Leadership Committee presented a Cardiovascular Seminar titled “Young Cardiovascular Surgeons and Anesthesiologists Committee Forum,” in which they discussed educational, professional and conflict of interest issues especially pertinent to young surgeons and anesthesiologists.

Another high point of the meeting was the Vivien Thomas Young Investigator Competition, in which five outstanding young investigators presented their work to some very critical judges. This year’s finalists were:

- Mitesh V. Badiwala, Toronto General Hosp, Toronto
- Wolfgang Bothe, Stanford School of Medicine, Stanford, Calif.
- William Hiesinger, University of Pennsylvania, Philadelphia
- Shizu Oyama, Alpert Medical School of Brown University, Providence, R.I.
- Jabaris D. Swain, University of Pennsylvania, Philadelphia

Mitesh V. Badiwala won the competition with his talk, “Epidermal Growth Factor-Like Domain 7 is a Novel Inhibitor of Neutrophil Adhesion to Coronary Artery Endothelial Cells Injured by Calcineurin Inhibition.”

This year, Dr. Loren Hirtzka received the CVSA Council’s Distinguished Achievement Award for his many years of service to the Council and the American Heart Association. Dr. Hartzell Schaff won the Outstanding Mentor Award. Recipients of these awards and the Vivien Thomas finalists received their plaques at the Annual Business Meeting and Dinner at Chicago’s Gibson’s Steakhouse. At the CVSA Leadership Meeting on Nov. 13, committee members discussed ways to maintain and increase Council membership and extended an invitation to perfusionists and anesthesia and surgery colleagues from Europe, Asia and South America. Vice Chairman and Research Committee Representative John Ikonomidis presented the research report and Richard Weisel gave a summary of advocacy activities. There has been a marked increase in the number of scientific statements and guideline papers sponsored or co-sponsored by our Council and in our involvement in “You’re the Cure,” which demonstrates our role in attaining the goals of the American Heart Association. Finally, we would like to welcome new members to the CVSA Council, including cardiac and vascular surgeons, anesthesiologists, perfusionists, nurses and other healthcare personnel. Please visit my.americanheart.org for more information on our Council.

William W. L. Glenn Lecture
Left to right: Frank Sellke, MD, FAHA (Chair); lecturer Joseph Reves, MD; John Ikonomidis, MD, PhD, FAHA (Vice-Chair)

Vivien Thomas Young Investigator Award
Left to right:
Winner Mitesh Badiwala; Frank Sellke, MD, FAHA (Chair)
I Hung The Moon!

Don’t forget to nominate your co-workers for going ‘Beyond the Call of Duty’. I hung the Moon slips are available at the 3rd floor front desk, and may be turned in to Rhonda or Kim. Thanks so much!!

Macy Westby & Zack Lamb: Great help with a very sick level care Trauma patient that required multiple blood products. Never once did I have to think who was running the rapid infuser. Thanks!

Beth Jennings: Great team player, Scrambling to help me set up for an early start case.

David Stoll: Steadfast attitude in support of patient care.

Tom Epperson: Steadfast supportive attitude in response to a stat page.

Alan Finley: For being very patient and helping me improve my FOB skills

Kenneth Grismore: Impressive set up of Rad. Onc., CT and ROR today and everyday!!

Ray White: Excellent patient care & indisputable perseverance in a patient with tenuous IV access requiring transfusion & repeated LABS pre-operatively. Ray literally stood by the patient.

Myra Coe: Attentiveness to a very complicated patient in an outlying location with high anxiety & a previous poor sedation experience.

SAVE THE DATES:
- Resident Graduation, Friday, June 24, 2011, Charles Towne Landing
- Holiday Party, Friday, December 2, 2011, Carolina Yacht Club

April 2011 Standard of the Month

Manage Up:
- speak well of each other,
- co-workers, and medical staff.

We Would Love to Hear From You!

If you have ideas or would like to contribute to Sleepy Times, the deadline for the May edition will be April 18, 2011.